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TRIP REPORT NO. CAR/KYR-?

FINANCIAL MANAGEMENT OF THE FGP'S AND ORGANIZATIONAL DEVELOPMENT OF MHIF/OHD IN THE ISSYK-KUL OBLAST DEMONSTRATION AREA, KYRGYZSTAN

September 17 - October 14, 1995
Karakol, Kyrgyzstan

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I. EXECUTIVE SUMMARY:

The health system of the Issyk-Kul Oblast Intensive Demonstration Site (IDS) is in the process of undergoing a major transition from the traditional Soviet model, dominated by medical specialists, to a primary care oriented family medicine delivery system. A Mandatory Health Insurance Fund (MHIF), with a capitated rate to cover the family practitioner population, and a per case payment system for hospitals is being established. The present system is built heavily on a number of specialty hospitals, polyclinics, and dispensaries. The old system favors large numbers of admissions to hospitals, long lengths of stay (LOS) in the hospital, heavy referrals to specialists, and large numbers of visits to ancillary services and out-patient polyclinics. If the transition to a primary care focused system, centered around Family Group Practices (FGP's) is successful, and if the capitation rate and case base system is designed properly, this should reduce referrals to specialists and ancillary services, as well as reducing the number of hospital admissions and average length of stay (ALOS) in hospitals.

This was the consultant's second visit to the beautiful city of Karakol and the Issyk-Kul Oblast. The objectives of this second trip were to continue to assist with the design and development of an information, accounting, and financial system which would meet the needs of both the newly formed FGP's, and would provide information to the Mandatory Health Insurance Fund. Further objectives of the visit were to review and assess the proposed MHIF Fundholding structure and management systems, to review the problems and possibilities of increasing levels of management autonomy for facility managers, and to review the need of computerization of accounting systems for the health facilities.

The results these consulting activities are as follows:

- The implementation of Stage I of the information, accounting, and financial system was begun with the development and trial run of a beginning clinical information system utilizing a physician's charge/data sheet which was designed to capture the relevant data (office visit, home visits, referrals, and diagnosis) that are needed by the MHIF and the FGP's for the monitoring and control of capitation payments.

- Some additional progress was made on designing and developing the MHIF Organizational Structure and Fundholding System, with coordination of control and authority of the MHIF with the Oblast Health Department (OHD).

- A review of the problems and possibilities of increasing levels of Autonomy for Head Physicians of Health Facilities led to a number of recommendations for a partial and phased in program which will meet the needs of the facilities and also fit the existing cultural and operating styles of management, but it will not be easy to implement.

- A review of the needs and capabilities of the accounting systems in the health facilities led to a recommendation to computerize the existing cash basis, one entry, fund accounting system presently being utilized at all facilities, and not attempt to develop and implement a western style accrual base, double entry, accounting system. This approach is more likely to be adopted, utilized, and replicated than a completely new westernized approach.

II. BACKGROUND

This trip report is a review of the work which occurred during the consultant's second visit to the IDS in Karakol, Kyrgyzstan. The trip was carried out during the period of September 17 through October 14, 1995. The major focus of the trip is the continuing design, development, and implementation of a manual financial, management, and information systems for the Family Group Practices (FGP's) in the Issyk-Kul Oblast Demonstration Area, Kyrgyzstan. A number of previous reports on the overall developmental needs of the FGP's were carried out during 1994-1995, and are listed in the Reference Section of this report. The major objectives of this constancy were to continue the institutionalization process of the financial and management information system for the FGP's. In addition, continuing efforts were to be expended in the development of the Mandatory Health Insurance (MHI) Fundholding structure, strategy, and implementation plans. A further initial objective was to conduct a two day workshop for the board and management of the new MHI, but this objective was delayed during the visit due to new leadership of the OHD and the time for her to become familiar with the issues involved. Due to this delay, other items were added to the scope of work, including a review of Autonomy in the IDS and a review of the computerization of accounting systems for Health Facilities. In addition, some work was done on the feasibility of a Revolving Drug Fund, but this information appears in a separate report. The definitive objectives and Scope of Work (SOW) for this constancy is listed below.

III. OBJECTIVES

The SOW, major objectives, tasks and outputs for this consultant were as follows:

- To implement Stage I of the FGP's information and data collection system.

- To assess the continuing needs, requirements, and capabilities of the FGP's, and outline the specifications for Stage II of a primary care management and financial operating system.

- To identify and assess the continuing development of the management structure and key relationships between individuals and institutions with regard to the MHI fundholding system.

- To review and make recommendation on the development of Autonomy for Health Facility Managers.

- To review and make recommendations on Computerization of Health Facilities

IV. FINDINGS AND RECOMMENDATIONS

A. Development and Implementation of Financial and Management Systems for Family Group Practices

1. *Background*

Identification of the need to support the development of the FGP's with some type of accounting and financial system was highlighted early in the project development. Considerable background investigation was carried out (see prior trip report) and this consultant was contracted to develop a manual information, accounting and financial system for the FGP's in the IDS, which would lead to computerization in a later stage.

The most common system, and the system utilized in thousands of physician offices and small group practices is known as the "pegboard system". "Pegboard" refers to the position board, which has pegs in it to align the various forms. These pegboard systems are used in physician offices of one to ten doctors, and vendor salesman have estimated that a system for a four doctor office could be set up and operating with all form for a year for about $800-$1000. These systems are used in a number of countries and can be translated into whatever language is desirable. It was decided that a modified Pegboard system would be implemented in the FGP's, and that this would be implemented in three stages.

2. Needs, Requirements, and Capabilities

The FGP's are in need of a simple, effective financial and information system which will provide utilization (visits, referrals, diagnosis) and cost data both to the MHI capitated fund, and to the physician groups themselves. The revenue side of the accounting function is non-existent (there are no charges for services and only minor user fees are charged and seldom collected), and the normal expense side (salaries, supplies, rent, energy, etc.) is housed either in the hospital/polyclinic accounting office, or the central rayon accounting office. Consequently, the implementation of the

Pegboard Business System in it totality, would not make sense at this time, as the system is "revenue driven", and there are no revenues, nor are there any expense allocations. As a result, we have recommended the modification of the Pegboard Business System into a number of stages, which will meet the needs of the BHI, and can be implemented in stages as the project develops.

3. Specifications for Manual Information Systems

During this consultant's visit it was highlighted that the FGP's will need and Office Manager type position in order to develop and implement any type of Group Practice Office operating systems. This concept has been reviewed with the IDS and accepted for implementation in the near term. The specifications for the new system (**as outlined in the first trip report**) are reproduced here for reference purposes:

- The system should be simple and easy of operate by the personnel working in the group practice.
- The system should begin during the registration process (or ideally at time of appointment scheduling, but appointments, excluding home visits are not done with any frequency).
- The system should fit easily into the existing record keeping and information collection and should not require significant amounts of new information.
- The system should not be data intensive (at least until computerization is approved), and should stick to the basic data needed by the MHI fund and needed for monitoring of productivity between physicians in the group and between different groups.
- The system should be designed so that it is computer ready and can easily be expanded and computerized in the second phase.
- The system should capture revenues, cash, and expenses, as well as statistical data on utilization, types of visits and procedures by procedure code, referrals to specialists and ancillary services (lab, x-ray, ultrasound, physical therapy, etc.), and hospital admissions.
- The system should be designed to accurately measure and report budget vs. actual statistics, revenue, cash, and expensed on a monthly basis.
- The system should be a cash basis, fund accounting approach which will fit into the existing Oblast Department of Health financial and accounting system.
- The system should follow the normal accounting structure of journals, accounts and sub-accounts, but should utilize the existing chapter structure used in the hospitals.
- The various elements of the Pegboard System should be phased in as conditions allow and as revenues and cash become a larger part of the overall system.
- The system should begin with data collection and reporting statistics for the MHI as the first initial step, and should be followed by account cards/ledgers, and then journals as the system develops and revenue (directly from patients) becomes more important.

4. Recommendations

Outlined below are the recommended implementation stages for the information, accounting, and financial system for development of the FGP's:

STAGE I: Clinical Information for the BHI and FGP Utilization

The initial stage is a data collection and clinical information stage which will get the process started and will provide the BHI will the needed information on the FGP's. The system has been designed around the Pegboard Business System beginning steps of a Data/Charge Sheet which utilize the international CPT-4 Procedure Codes and the ICD-9 Diagnosis Codes and contains the following information:

- Office visits and Office Procedures (type and quantity)
- Home visits and Home Procedures (type and quantity)
- Drugs and Pharmaceuticals (Free and User Fees)
- Referrals to Specialists at the Polyclinics (Type of Specialists and Type of Polyclinic)
- Referrals to Ancillary Services (Type of Service)
- Referrals to Hospitals for Admissions (Type of Hospital)
- Diagnosis (Preliminary and Final, and Major or Minor)

(See Exhibit 4 for Examples of Charge/Data Sheets)

The implementation of Stage I is presently underway and a trial period has been completed and the Charge/Data Sheets will be pre-printed in Almaty for use by all FGP's presently in operation. The early collection of this data will also form the baseline data set for the evaluation of the changing behavior of physician, polyclinics and hospitals within the IDS. This data will be collected at each existing FGP for one month prior to the initiation of any changes in training, equipment, supplies, drugs, renovations, etc.

STAGE II: Beginnings of Formal Accounting System

The timing of the implementation of the second stage of the information, accounting, and financial system for FGP's will depend on a number of factors. The first, and most important is **revenues**, and will depend on whether User Fees for services are approved for implementation, and/or the BHI begins making direct payments to the FGP's, and the FGP's have an independent bank account. The second factor is the **expense** side of the accounting system, which will depend "if, what, and when" FGP's are allocated expenses from the OHD (rent, electricity, heat, overhead, etc.), and if they will be paying their own salaries, salaries of their staff (nurses, office managers, etc.), as well as expenses for supplies, equipment, materials, and other incidentals of operating a group practice. The third factor is the hiring and training of **Office Practice Managers**, which are necessary if any clerical or financial and accounting activities are going to take place. These positions have been approved and are presently being recruited. All of these items are presently under discussion, but no decisions have been made. Without Revenues and Expenses there is no need for a formal accounting system.

Pending approval and decisions on the above items, the following systems will come into operation:

- The manual Pegboard Business Systems Accounts Payable Section will be utilized for the expenses of salaries, wages, benefits, deductions, rent, supplies, etc.
- The manual Pegboard Business Systems Accounts Receivable Section will be utilized for the revenues of BHI capitation payments, user fees, other collections, etc.
- The FGP's Financial System will have an annual and monthly budget plan, as well as monthly variance reporting..
- The FGP's Financial System will have a monthly productivity report to monitor the performance of each physician.

(see Exhibit F of Previous Trip Report for list of various Pegboard Sections)

STAGE III: Computerization of Accounting Systems

The third stage of the information, accounting, and financial system will also depend on a number of factors, including the independence of these family practice groups from the OHD. If and when the FGP's have a formal legal structure, a separate bank account, office managers, payroll to meet, expenses to pay, revenues to collect, user fees to request and receive payment for, and a variety of other factors, including increased volumes of activity, and hopefully decreased referrals, then the group practices will need some form of computerization. This does not necessarily mean that computerization could not come before all of this occurs, but the cost effectiveness of computerization would be more justifiable when all of this comes about. However, the Pegboard Business System is designed with computerization as a pre-condition of implementation.

B. MHI Fundholding Management Structure and Systems

1. Background

The development of a Fundholding System for the MHI has been discussed and worked on from the beginning of the project. The major change in the delivery system is a shift from a focus on specialty care to a family oriented primary medical care system. This system has similar elements to the British Health Service (BHS). Personnel from the Intensive Demonstration Site have traveled to the United Kingdom to learn about this system and have returned with some valuable information and knowledge from their experience. Unfortunately, the BHS Fundholding System is highly complex due to the number of years it has been under development, and has a large number of pass through items (most salaries for nurses, some capital equipment, etc.) not covered under the capitated rate program. Much of the BHS experience and system is **not** relevant, at this point in time to the program being developed in the Issyk-Kul Oblast. However, a number of elements are valuable and will be incorporated into the Fundholding System for the IDS.

2. Relationships

The organizational structure and relationships within the MHIF have been proposed and follow some of the general concepts from the Kemerovo Project (Russia). While all of the positions, functions, and reporting has **not** been finalized or approved, an October update of the most recent thinking, plans and proposals are as follows:

- There will be a board of 13 members made up of a broad segment of the community and of Oblast Health Department personnel.
- The Chairperson of the Board will be the Head of the Oblast Health Department
- There will be a CEO or General Director of Fund, who will be the Deputy Head of the OHD.
- There are two Deputy Directors of the Fund under consideration, one for Medical Care Issues, and one for Finance/Fundholding Issues.
- There is a separate Directors of Affiliates, that will look after tax collection.

There will a separation of the organization structure of the OHD and the MHIF, with some functions and personnel **shared** between the two organizations and some personnel and functions distinctly **separated**. These are still under discussion.

(see Exhibit 2 and 3 for Job Descriptions and Organigram of OHD)

- There will be a Medical Expert Department with a surgeon, a pediatrician, a obstetrician/gynecologist, and an internist..
- There will be a Statistics and Computer Department with various staff overseeing the medical statistics, monitoring and reporting..

- There will be a Accounting Department with various staff reporting to the Deputy Director for Finance/Fundholding.
- There will be an Administrative and Logistics Department with various technical staff (Lawyer, Insurance Agents, and other technical staff as needed).

3. Recommendations

This consultant was requested to review and assist with the Fundholding System and the new Organizational Structure of the MHI Fund and the OHD. The recommendations outlined are both general and specific in nature and apply to all aspects of the MHI Fund/Fundholding System, and are **updated** from the July report:.

Items To Consider in the New OHD/MHIF Organization:

Attempting to combine the elements of the new MHIF Organization with existing elements of the OHD will **not** be an easy task. The inherent objectives of both groups are somewhat **different** and the necessary coordination and communications between the two groups is critical especially in the area of rationalization of facilities and services.

Health Departments, by their very nature, are interested in public health, primary health care (PHC), increasing services to the public, high quality medical care, and a variety of issues concerned with improving the health of the population. These public health objectives usually result in **additional cost.** On the other side are the objectives of the MHIF, a **Health Insurance** Fund, whose objectives are often different, and are usually less services, cost effective services, cost effective quality medical care, and in many cases the development of a rationalized health system, usually meaning**less facilities and less cost.**

In the process of developing a combined Organization Structure for the OHD and the MHIF, the organization should be clear of the joint objectives of the two groups together. Outlined below are some proposed **joint objectives**: for the two groups**:**

- **To develop a cohesive structure for coordination and cooperation in decision making.**
- **To develop strong communication systems between the two groups to reduce conflict in the process of rationalizing facilities and services.**
- **To develop a structure which allows each group to do "what they do best" without undue interference from the other group.**
- **To minimize the cost of new positions and new functions in setting up the MHIF.**

In thinking through the development of the new structure, it is always best to think**small** in the beginning, only adding positions/functions as they are really needed, and ensuring that each new position can be justified. Another element in planning the new organization should be a "**transition**" **plan,** which slowly and carefully moves functions, activities, and

funds from one area to another, setting specific objectives and time frames for each element of the transition. This slow but steady approach allows new personnel time to learn their new jobs, and gives the new management and the new board time to learn the new responsibilities and new methods of operation. Running a Health Insurance Fund is **very** different from running a Health Department and everyone will need time to adjust to the new demands.

This consultant is not proposing a specific new organizational structure at this time, as the Zdrav*Reform* team and the OHD need to sit down and discuss a variety of issues before any organization structure is decided. The consultant has reviewed some possible options with the Zdrav*Reform* Program staff but they are not included in this report. However, outlined below are some recommended work issues for both management and the board as they go forth in developing the new combined structure of the OHD/MHIF:

Work Items for the Board:

- The working structure and membership for board, and board committees needs to be outlined and developed.
- The board committees should consist of the normal oversight functions of **Finance, Quality Assurance, Audit (both medical and financial), Fundholding, Community/Public Relations**, and others as the need develops, as well as a small **Executive Committee** (3-5 persons) for timely decision making when the full board can not meet. There also appears to be a need for a **Medical Care Delivery System Oversight Committee** which would oversee the needed changes in the education, training, treatment methods, consolidation of facilities, and service delivery.
- The Board should probably also have a position/function of '**Secretary to the Board**" to oversee, organize, distribute, and follow up on agendas, meeting, board papers, and other administrative functions of the Board.
- The board will need a set of articles of incorporation and bylaws.
- Board committees should be kept small, with 5-7 persons as official representatives, and various other being added as unofficial members, as needed.
- Board committees should have at least one member of the larger Health Fund Board, in order to provide feedback to the larger board on policy issues, but can, and in most cases should, bring in other members from the community, in order to broaden the base of needed skills and background. An example might be the Finance Committee, which would have the key board personnel as official members but may want to bring in non-board community specialist in insurance, capital development, etc.
- **The Fundholding Committee** should have representatives from each specialty making up the FGP's, plus finance and medical/quality assurance personnel, and the committee should have responsibilities for reviewing recommended budget capitation rates, utilization statistics (referrals, laboratory, etc.), changes to the size of group practice enrollments or catchment areas, and other issues related to physician payment and

compensation. The Fundholding Committee may need its own subcommittee on Finance as the level of understanding the detail may be critically important.

- Another important task in the Board/Management area is the development of descriptions, functions, and responsibilities of board and management committees and subcommittees.
- The functioning of a MHIF **Board** is very **different** from the functioning of a Management **Committee** and a workshop is planned to allow all participants to understand the similarities and differences.

Work Items for Management:

- Organizational and staffing issues such as the development of job/position descriptions for all of the new and proposed positions.
- There are a variety of Board/Management issues such as distinguishing the different roles, responsibilities and authority of each element of the governance/management process. A workshop/retreat to discuss these issues is being planned. **Ideally this should be done before finalizing the OHD/MHIF organizational structure.**
- The MHI Board and Management will also need to begin thinking about strategic issues and it is not too early to consider a board retreat to do some strategic planning.
- The one key function will be Finance and a key task in this area is the development of a "Sources and Uses of Funds" document which is the major financial forecasting and reporting vehicle. It is the understanding of this consultant that this is presently being completed.
- In developing the organizational structure strong consideration should be given to having a Finance/Fundholding Department in the MHIF which is different than OHD.
- Another key task for management to begin working on the contracts between the Fund and each of the Primary Care Group Practices and the contracts between the Fund and each of the Hospital/Polyclinics and other providers having some relationship with the MHI Fund. It is the consultant's understanding that this is also being completed.
- Finance will undoubtedly be the biggest area of concern and the best possible finance personnel should be recruited as soon as possible.
- Some consideration and planning needs to be focused on the development of information that will be going to top management and the board. While it is early in the development of the MHIF, and it is the understanding of this consultant that significant work has already gone into the development of an Information systems and a MIS, the level and detail of information at each level needs to be developed.
- Reports for HMO Institutions normally fall into the following classifications:

  a. Board Level Reports (Membership, P&L, Balance Sheet, Cash Flow Statement)
  b. Membership and Marketing Reports
  c. Financial Management Reports (very detailed)

d. Health Service Reports
(note: List is from *HMO Critical Performance Measures for HMO Management and Board,* published by Birch and Davis)

- The benefit packages of services which are covered by the capitated payment also needs more discussion, especially with regard to home visits and ambulance calls.
- Some thought should be given to the issue of whether or not the FGP's will be able to competitively "bid out" their ancillary services (lab, x-ray, p.t., etc.), or do them in-house with their own personnel and equipment, or if they are going to be at the mercy of the prices set by the hospital/polyclinics.
- These above mentioned two items will become Fundholding issues very quickly once the FGP's see their revenues being reduced without much control over the price.

C. Management Autonomy for Health Facility Providers

1. Background

The issue of improving management autonomy within the Issyk-Kul IDS has been part of the original design of the project and has received considerable discussion over the last year. While this item was not part of this consultant's original scope of work, it was requested that a preliminary paper be prepared to outline some of the issues, problems, and possibilities. The following section is not meant to be an in-depth discussion, but is rather meant to be a preliminary review of the topic, from the consultant's general management background and familiarization with the difficulties of implementing autonomy in health facilities while working in over fifteen countries during the last twenty years.

With the proposed changes in the payment mechanism within the project comes the question if and how providers of health/medical services (Hospitals, Polyclinics, FGP's, SUB's, SVA's, etc.) can adjust their behavior to take advantage of this new environment. The existing top-down, command and control, centralized planning environment does not lend itself to the flexibility and risk-taking behavior that will be necessary to effectively and efficiently adjust to the possibilities which will be forthcoming.

A number of papers have been written and part of a course has been presented on the issues of "Autonomy". The various benefits of Autonomy (cost, quality, efficiency) have been spelled out and reviewed with managers in a previous management course (Health Facilities, Management, and Budgeting), and is also the major part of a new course under development by the Zdrav*Reform* Program staff in Bethesda. This first course was a description of what Autonomy means and how it works within existing Western systems. However, the course did not cover the "how" or the "why" of decentralization and autonomy with respect to work within the IDS.

The existing structure of the MOH, MOF, Treasury, OHD, Municipal and Oblast Administration, and the financial constraints of these organizations have been well

documented elsewhere and need not be repeated here. The need for a "performance-based" pay system and autonomy for managers has also been well documented. Some original proposals to put employees on a yearly contract basis has also been recommended, thereby allowing managers more flexibility in staffing decisions. The findings and recommendations which follow are meant to supplement the work which has already been completed.

2. Findings and Analysis

Without repeating most of the information already developed, it is necessary to provide some conceptual framework for the topic and issues under discussion:

Within a health care environment "Autonomy" normally falls under the management area of "Decentralization". Moving from a centralized structure (where a few specialists make most of the decisions with regard to resources) to a decentralized structure, which pushes down the decision making process to lower levels in the organization to allow managers (who are closer to patients, have more knowledge of local needs and capabilities, and have the most information on the local situation), to make the major resource decisions.

It is believed that a decentralized structure allows more risk taking, and more creative solutions to the problems of cost, efficiency, productivity, quality, access, financial viability, etc. The major trend internationally, over the last twenty years, in both commercial business enterprises, and increasing in non-profit public services, has been toward increasing levels of autonomy for middle and lower level managers. Both practical experience and various studies have shown that the decentralized decision making process is both more effective (i.e., "doing the **right** things") as well as more efficient (i.e., "doing things **right**").

In reviewing the information on autonomy within the ZRP and in being involved with the overall objectives in the Issyk-Kul IDS, this consultant's knowledge of the topic has lead to the following **objectives for increasing levels of management autonomy** within the project:

Proposed Objectives:

- **To improve the cost effectiveness of providing health/medical services** to the population through allowing facility managers more flexibility with regard to financial decisions regarding staffing/manpower levels (types/quantities of staff, hiring/firing of staff), drugs and pharmaceuticals, supplies, equipment, training, renovations, capital equipment, and other financial related items.

- **To improve the quality of health/medical care** by allowing facility managers more flexibility in decisions of the types of admissions, the length of stay of admissions, the in-patent versus out-patient treatment of specific diseases, the procurement of specific

efficacious drugs and pharmaceuticals, and the improvements in technology and modalities of treatment.

- **To improve the access and satisfaction of health/medical care** by the population by allowing managers more flexibility in decision making in order to improve the attitudes and behavior of staff, the condition of buildings and equipment, the availability of drugs and other supplies, as well as the overall acceptance of institutional care by the public.

Within the context of these objectives, outlined below are this consultant's analysis and findings, as well as recommendation which follow, with regard to the implementation possibilities of increasing levels of decentralization and managerial and financial autonomy by health facility managers. The comments are not meant to discourage the reader, but to lend a degree of practical reality to the task ahead:

- **It will *not* be easy.** While this may be somewhat of an understatement, it is meant to highlight the difficulty of attempting this exercise. The history, the existing attitudes, the habits and behavior patterns, the existing command and control structure, the rigid budget/financial/cash controls, the lack of risk taking experience, the lack of democratic selection and election processes, and the unfamiliarity with performance based incentive systems on the part of the MOH, MOF, Treasury, OHD, Municipal and Oblast Administrations, Hospitals and Physicians, will make it a extremely difficult task. This does **not** mean it should not be attempted, but that the project should be committed to authorizing the funds, the energy and the time to bring this about.

- **It will take *major* changes in Financial and Human Resources Practices.** The two major areas of improving autonomy are in the areas of budget/finance and in the areas of personnel administration (appointments, hiring/firing). These are the two existing areas which are the most tightly controlled and the most difficult to change, in the present environment. The existing economic conditions in the country and the importance of job security will not lend themselves to major changes in either planning or control of either area in the near future.

- **It will *not* happen very quickly.** The lack of timely decision making, the consensus style of making key decisions, and the political difficulties in making major change are well documented. The interrelationships and interdependence of the MOH, MOF, Treasury, OHD, and Municipal and Oblast Administrations, will require significant levels of coordination, communication, meetings, reports, recommendations and study by all of the parties involved.

- **It will need to effect *all levels* of authority.** It will not be possible to bring about change within the autonomy of health facilities without having some effect upon all levels of the planning, administration, and control of health services. The OHD will not change without changes at the MOH, MOF, Treasury, Municipal and Oblast Administrations, and the Oblast Hospitals/Polyclinic facilities will not change unless the OHD changes, and the FGP's, and the Rayon Hospitals, SUB's, SVA, etc. will not change unless the Rayon Administration changes. It will be necessary to identify who presently has authority and control for each of these organizations, as well as how that authority is to be exercised.

While all of this is already known to IDS project participants, and in light of the above comments, some realistic recommendations follow in the next section.

3. Recommendations

Outlined below are the key recommendation for bringing about more Autonomy:

- **Strategic Planning and Board/Management Workshop for OHD/MHI and Heads of Major Health Facilities**

With the emergence of new leadership within the OHD and the BHI and a new cast of players, there is a need to review in-depth the purpose, objectives, information, activities, and processes of the IDS. This is now underway and hopefully the new head of the OHD will have a clear picture of the total project. At the conclusion of her familiarization with all of the issues, there is a need to bring the new team into a Strategic Planning Process Workshop which allows them to work through the new issues and strategic direction. This is best completed with an OHD/BHI Strategic Planning Workshop, conducted over a two or three day period which will assist them to focus together as a group on the new Mission, Vision, Strengths, Weaknesses, Opportunities, Threats, Critical Issues, Goals, Objectives and Program Plans for the coming 1-3 years. This could be conducted separately or in conjunction with a Board/Management Workshop: Increasing Board Management Effectiveness, which is necessary with the new BHI structure. These two workshops, or one integrated workshop could go a long way in bringing together all the key players into a consensus seeking process to agree on direction for the coming period.

These workshops could also set the stage for improving cooperation and reducing conflict between the two groups, as well as setting the stage for increasing Autonomy for health facility managers. There is also a strong need for development of teamwork skills among OHD, BHI, FGP, and other groups, as the existing structure is still very authoritarian and does not facilitate itself toward collegial learning among different disciplines and between various levels of authority.

- **Management of the Oblast Health Facilities as a "Health System" with Partial and Phased-In Autonomy**

While "Autonomy" often connotes "full autonomy" in the minds of most participants, we know by experience that this does not fit reality. Large businesses and health care organizations, who operate a large number of facilities, practice only "partial" decentralization and "partial" autonomy. These organizations have a number of both "tight" and "loose" elements/properties with respect to autonomy. A "tight" property are those things which are felt to be managed best from a central authority, an example would be "cash flow" or "capital budgeting and control". A "loose" element are those felt to be managed best by local authorities, and example would be staffing decisions (appointments, hiring/firing).

One international health care example would be the Hospital Corporation of America (HCA), which operates or manages hundreds of hospitals internationally. While local managers, have a local "advisory" board, and have considerable local autonomy about general operations (personnel, finances, quality, etc.), they are carefully observed by "corporate" personnel and board who release cash, set standards on staffing, quality assurance, etc.

With respect to the Issyk-Kul Oblast, it is recommended that the participants work out a list of possible priority autonomy areas (hiring/firing or personnel, flexibility in spending within and between budget categories, quality assurance, etc.) which are in need of some change (if health facility managers are to exhibit more risk taking behavior), and that the project work towards developing a consensus among the key parties toward experimenting with these changes. This list of autonomy priorities could be developed by a task force of local hospital head physicians, possibly with the assistance of an outside consultant or project personnel, and some possible schedule and time frame for implementation be developed, and a consensus be formed around the need and approval for these changes. This type of partial, slowly phased-in, process might be less threatening to the major decision makers, and be more in line with present methods of operation and control.

- **Continue Management Development/Management Training**

The project has initiated and conducted a number of management development and management training programs, including study tours, on-sight courses, written materials, etc. With the dominance of the existing system with physician heads of health facilities, there is a need to continue to professionalize "hospital management" as a discrete discipline, and this should be a high priority for the IDS. The availability of the Karakol Management Institute should be utilized to conduct an increasing level of management courses for hospital heads that cover the full range of Hospital Administration activities. The project should also sponsor continuing courses and materials prepared and presented by health care management professionals from other countries. There is also a strong need to develop a helping relationship between disciplines in the area of Quality Assurance, as the JCAHO model of possible punitive actions for non-compliance could be taken in a negative form if not understood correctly, and not combined with effective training and education in these areas.

- **Development of Local Advisory Boards at All Major Health Facilities**

There is nothing better than a local hospital board, made up of a wide variety of the community representatives, to focus the attention of a hospital head on the issues of finance, cost, quality, access, and service to patients. These local advisory board, meeting monthly, could focus attention upon the need to improve services and still retain financial viability. While this is a somewhat new concept, it has worked successful in a number of countries, and has been the backbone of developing community "governance" of local non-

profit health facilities. While the boards could be "advisory" to begin with, they could quickly develop into fully functioning Governance boards, as these major health facilities move toward more independence from the OHD, and possible privatization over the period of the next decade. The development of these advisory boards could be coordinated with a workshop on Board/Management Effectiveness, which covers the principles of an independent, community responsible board and management for non-profit community hospitals which has proved successful in a number of countries.

- **Contracts for Personnel and Performance Based Pay Systems**

One recommendation which has been proposed in the past, with regard to allowing facility managers more autonomy in the personnel area, has been the proposal to health care personnel on short-term contracts of one year. This would allow health facility managers more flexibility in staffing by renewing or not renewing personnel contracts based on need, performance, etc. Another proposed idea was to develop performance pay systems which reward personnel based on merit. While both of these ideas have considerable merit, it is this consultant's experience that **both of these are extremely difficult to implement and to administer**. They are at best, very short term solutions to a serious financial crisis. Taking into consideration the present economic and political environment in Issyk-Kul Oblast, these two ideas should **only** be attempted after other measures have failed, and a financial crisis continues.

D. Computerization of Provider Accounting Systems

1. Background

During the early stages of the Issyk-Kul IDS project the need to assist the provider organizations (Oblast and Rayon Hospitals/Polyclinics, FGP's, SUB's, SVA's, etc.) with financial, managerial and cost accounting was identified. Along with this need for new accounting and financial systems and training came the need to assist with computerization. In order to assist the institutions to understand the new payment, an environment is the need to assist them with developing data and reporting to analyze and effectively deal with the changes. Early efforts focused on training and the development of computerized step-down cost and cost allocation systems. Considerable effort has gone into this part of the project, as well as the activities related to the development of an information, accounting, and financial system for the FGP's which is underway. Some initial investment has gone into exploring computerize accounting systems for health facilities with the purchase, and review of the "Peachtree" system and the " MEDASOFT One-Write" system.

As an addendum to this consultant's scope of work, was a request to look into the need, problems, and possibilities of assisting the hospitals/polyclinics with computerization of accounting and financial functions. This paper is a preliminary review of this aspect of the project, and is not meant to be an in-depth review. The consultant has had some twenty odd

years of experience with information, accounting, and financial systems in hospitals, clinics, and physicians offices, including both manual and computerized systems. The findings, analysis, and recommendations which follow should be taken in light of that experience.

2. Findings and Analysis

This consultant's work in the project has been focused around the development of the clinical and charge information, accounting, and financial system for the FGP's, as well as work on the rationalization of the health system and development of the MHI fundholding system. In working with the hospitals and polyclinics, at both the Oblast and Rayon levels, this consultant has been able to observe and discuss the existing information, accounting, and financial systems.

As has been well documented elsewhere (see Annex: Haycock, Hildebrand, Telyukov, Gass, et. al.) the existing accounting system is similar to a Western cash basis, Fund Accounting Approach with a small number of budget chapters, of which only a few are ever funded. This system exists throughout the old Soviet Union and personnel are well trained, collect large amounts of data, but the information is seldom used for timely decision-making nor is there much trend analysis nor managerial cost accounting/cost allocation. The concept of a Profit and Loss Statement is understood, but a Balance Sheet is less well understood and is not a major managerial tool..

Considering the new payment environment, which is both a mixture of capitation and case based payment, the hospitals will need to better understand their costs, revenues, cash flow, expenditure of resources, trend analysis as well as other modern management and financial tools. The ability to analyze workload trends and costs can greatly be expedited through the use of computerization. The cost of computerization has come down considerably over the last few years and is now cost-effective tool even for small hospitals.

A preliminary review of the needs, problems, and possibilities of the hospitals/polyclinics in the Issyk-Kul Oblast IDS has shown the following:

- There is a strong need to assist both the **Oblast and Rayon Hospitals/Polyclinics** with computerization of their information, accounting, and financial functions.

- There is a **strong opportunity, and minimal cost,** to assist hospitals with computerization of their information, accounting, and financial functions.

- There is a need to provide **continuing training assistance** in the areas of cost and managerial accounting and financial management.

- There would be **great difficulties experienced with attempting to change the existing accounting system to a Western model** of accrual basis, double entry accounting systems even with computerization, which is the "Peachtree" system" model recently purchased, and exists in both an English and Russian version.

3. Recommendations

The recommendations which follow are preliminary, and are meant to be viewed in light of the preliminary analysis and finding presented above.

- **Initiate an IDS project task to assist one Rayon and one Oblast Hospital/Polyclinic to computerize their existing cash basis, budget chapters, Fund Accounting System, in its existing form**. This approach will be much better received, will assist them to facilitate, improve, and speed up their present systems, is more likely to be continued after the conclusion of the project, and is more likely to be replicated throughout the Oblast. Attempting to convince them to develop and utilize a completely new, accrual basis, double entry system, could frustrate them, and they would probably have to operate the two systems side by side for reporting purposes, thus ending up with double work.

- **Utilize project computer personnel working with the "Peachtree" model format system of flowcharts, filenames, screens, logs, etc. to form the basis for computerizing their existing systems in its present form.** The use of the recently purchase "Peachtree" system can provide the necessary format and information flow in order for local computer personnel to computerize the existing manual systems. Project computer personnel, or outside contractors, should be able to follow the "Peachtree approach" to developing data entry systems, Accounts Receivable, Accounts Payable, Inventory, Payroll, Fixed Assets, etc. The "Peachtree" is an excellent system to use as a model.

- **Coordinate the newly developed computerized system with the Cost-Allocation Computerized Step-Down Model (see Annex: Hildebrand/ Telyukov) recently developed.** The tie in of these two system, if possible, would provide the accounting and financial personnel with a full range of cost, financial, and managerialtools to analyze their operations, and develop new possibilities in light of the new payment environment.

V. FUTURE ACTIVITIES AND WORKPLANS

Outlined below is a new list of activities/workplan to fully operationalize the FGP's over the next twelve (12) months. This is similar to the list from the first visit in July, but has been updated to add new information. As the project is front-loaded, most of the activities are scheduled over the next six months, and some will probably slip to the second six months.

Short-Term (Within Weeks and the Next Two Months):

A. Specific Activities To Be Completed by Karakol and Almaty Office Staffs Prior to Consultant's Next Visit

- Another section to the form will need to be added for Hospital Visits.
- A trial period for the forms should be developed in the Rayons.
- The Karakol office staff will need to continue to modify the form as the trial period shows changes that will need to be made to improve the form.
- Working with the Internists, Ob/Gyn, and Pediatricians, develop a complete list of procedures codes for each procedure, utilizing the CPT-4 code book. Tokon has already completed some work on the Clinical and Pathology Laboratory Codes, but the CPT-4 codes for the three specialties (Internists, Peds., Ob/Gyn) will need to be developed. This will require considerable work between Tokon and a translator. The focus should be on the most commonly used codes, which should appear on the charge/data sheets, and some work on the "others" category from the worksheets as they are developed. This will need to be reviewed and approved by FGP Prof. Assoc.
- After completion of the CPT-4 code numbers, these will need to be added to the charge/data sheets by Bakyt for pre-printing. Considering the computerization will be quickly following the manual system, every activity will need to have a number code.
- Provider codes for each Physician in the FGP's will need to be developed, as well as for the referral specialists, hospitals and polyclinics. Each provider (of all types) will need a different provider number. This will need to be coordinated with Andrea in Almaty and developed with the computer data systems for the MHIF. Eventually, the provider number can be pre-printed on the data collection and other data forms .
- A decision will need to be made with regard to what code will be used for the patient identification number (Medical Record #, ID card#, Birth registration #, etc.) at the

FGP. There has been discussion with Andre and Sheila O'Dougherty but a final decision is needed.

- After the initial trial of the new charge/data worksheets with the FGP's, a final version will need to be approved (Dean Millslagle and Sheila O'Dougherty) and sent to Almaty to be printed. Some initial order quantity will need to be determined, one-three months supply, for the number of existing and new FGP's. It is recommended that **not** too large a supply is ordered until all the bugs are worked out of the new data collection system. However, the supply will need to be large enough to secure a one months baseline data set for the future evaluation process (see Evaluation Section of this report).
- The collection of the baseline data set (office visits, referrals, diagnosis) should be started as soon as possible, i.e. not later that sometime in October of November latest, as one months data is needed **before** things change (new equipment, supplies, renovations, etc.).
- As things are already changing, the baseline data should be collected as soon as possible with tabulated results in each area (workload, referrals, diagnosis).
- Once the new pre-printed forms arrive from Almaty, it will be necessary to decide who should and how should the form be collected, and who will tabulate it at the end of the day, and at the end of the week or end of the month. Bakyt can assist temporarily but the office managers or the MHIF will need to pick up this function.

B. Two Month To Six Month Activities/Work Plan

- Develop and implement a professional association and begin meeting regularly and discussing key issues and making decisions (Completed)
- Develop an agreement on legal structure for professional association (In-Process)
- Decide on a new name for primary care group practices (decided on 6-6-95: FGP's)
- Develop and agree on legal structure for FGP's (under discussion)
- Form voluntary agreements among individual physicians about voluntary choices for group partners (still under discussion)
- Form a number of different models for primary care groups practices (In-Process)
- Decide on number/location of group practices in rural and urban areas (In-Process)
- Identify geographical locations and secure space for group practices (In-Process)
- Conduct marketing campaign to advertise MHI Fund enrollment (In-Process)
- Begin to form groups and put more into operation as conditions permit (7 functional and 5 formed, with 3 in Karakol in process of forming, with total of 32 planned)
- Secure necessary equipment and supplies to operationalize group practices (In-Process)
- Initiate training and educational programs for physicians in primary care techniques (In-Process with full time Family Practice Trainer for one year being recruited)
- Develop course materials and initiate training for physicians in Office Practice Management process and procedure

- Make decision on group practice manager (completed), and begin interview and selection process (In-Process with candidates being identified)
- Develop course materials and initiate training of group practice managers in Office Practice Management and accounting, business, finance, and information systems
- Implement basic structure of accounting, finance, and information systems (In-Process with Stage I being implemented)
- Continue to develop Stage II and III of accounting and financial management systems for FGP's
- Implement data and information system reporting to the MHIF to/from the Family Group Practices
- Develop a schedule of standardized user fees and initiate training and implementation
- Develop a business plan and monthly and annual budget for each practice
- Initiate standardized registration, and referral form, data collection and reporting process (specialists, ancillary services-lab, x-ray, etc.), and hospital admissions procedures
- Establish a bank account for each established FGP
- Determine which costs (rent, overhead, supplies, equipment, etc.) will be absorbed by the FGP's and which will continue to be absorbed by the OHD/MHI
- Develop and implement contracts between OHD and MHI fund and each FGP
- Initiate capitation payments as funds become available

C. Six to Twelve Month Activities/Workplan

- Continue training in primary care treatment and techniques.
- Bring more group practices on-line and slowly increase the number of operational units both in rural and urban areas (possibly 100 total).
- Develop and implement standardized staffing patterns, medical records input/output and office routine procedures.
- Implement reductions in all the various Data Books in each FGP's which contain large amounts of data , some now reported to the OHD and never utilized.
- Continue to look for new office locations in rural and urban areas.
- Continue training of Office Practice Managers.
- Hire and train new Office Managers as FGP's begin to form.
- Continue to renovate and refurbish office locations, and secure equipment and supplies.
- Develop physician and group practice productivity reports.
- Begin to analyze data from FGP's and MHI with respect to changing behavior.
- Begin to bring the out-patient specialty and hospital payment scheme into the Fundholding System.
- Initiate consolidation/merger of hospital/polyclinic facilities as education and treatment changes begin to take effect.

VI. EVALUATION

The process of evaluation normally involves a review of actual accomplishments against the original plans. Discussion centers around what went well and what did not, as well as why they did or did not go well, and finally making adjustments to future plans. Often, a report is written to outline the "lessons learned" which is shared with colleagues and other similar projects. This process is often made out to be much more difficult that it appears, and it is often consumes large amounts of staff time.

The consultant's experience with evaluation is, that while it is an important management tool, it is best kept simple, done frequently, and used as an adjustment tool to current plans as the project goes along, rather than one mid term and one final evaluation exercise. With these thoughts in mind, a simple effective evaluation process is outlined below:

With respect to the Consultant's Findings and Recommendations:

- Were the findings and recommendations reviewed in a timely manner with Almaty, Bethesda, the Oblast Health Department, and USAID? A period of 6-8 weeks (November 15-30) would be considered timely but possibly 8-10 weeks with translation difficulties (December 15-30).
- Were decisions taken in a timely manner with respect to the recommendation, and were any follow up studies conducted to verify or develop further? A period of 3-4 months would be reasonable (February 15-March 15).
- Were the findings and recommendation on the accounting, financial, and information system reviewed and acted upon in a timely manner? Was action taken?
- Were the items requested to be completed between trip two (September) and three (January 1996) actually done? These were basically developing a list of procedures each of the three specialties using CPT-4 codes, as well as finalizing the pre-testing of the data collection forms.
- Were the findings and recommendations on the MHIF Organization Structure reviewed and decisions taken in a timely manner?

With respect to setting up and collecting data for the overall Evaluation of the Family Group Practices:

- Was the necessary baseline data collected *before* implementation of any major changes (equipment, training, supplies, drugs, renovations, etc.).
- Was the baseline data *sufficient* to conduct a formal evaluation of the changes and the success or failure of the demonstration.
- Are plans underway to do a mid-point evaluation in order to make mid-course corrections if they are needed.
- Is the process and the procedure of the formal evaluation in the discussion and writing stages or is it still undetermined.

The consultant hopes that all of this is found to be helpful to the evaluation process.

VII. TRIP ACTIVITIES

September 16/17: Travel from Philadelphia to Almaty via Washington and Frankfurt, Germany.

September 18: Travel from Almaty to Karakol, and met with Dean Millslagle and Sheila O'Dougherty and the Karakol Office Staff to review progress and plans.

September 19: Met with Office Staff to review developments of CPT-4 and ICD-9 codes and charge/information sheet for the FGP's. Reviewed plans with Dean Millslagle and Sheila O'Dougherty. Instituted changes to charging sheet and directed efforts to secure CPT-4 procedure codes from World Health Organization (WHO) for use in Central Asia. Worked on outline for management course for James Glucksman and faxed to Bethesda.

September 20: Reviewed progress on charge sheet changes and CPT-4 procedure codes. Developed Abstract for Central Asian Conference on the *Development of Family Group Practice Accounting and Financial Management Systems.* Worked on charge sheet changes and reformatting of data sheets. Worked on outline of management course for James Glucksman and faxed changes to Bethesda.

September 21: Met with office staff to review marketing plans as well as the progress on charge/data sheets. Developed plans for Stage II of Accounting and Financial Management System. Reviewed Revolving Drug information and plans. Reviewed information and materials related to the Facility Accounting System (Peachtree Systems) and outlined possible issues of concern and possible planning parameters. Review course information on Autonomy issues from prior Abt workshop on Management.

September 22: Travel to Almaty for meetings with Michael Borowitz, Becky Copeland, Sheila O'Dougherty, and Chip Krakoff, and other Almaty staff on project plans and priorities, including FGP's development and the Revolving Drug Fund (RDF) Project in Kyrgyzstan.

September 23: Worked on Trip Report and project plans and changes to priorities, in light of previous days meeting with Almaty staff.

September 25: Travel from Almaty to Karakol. Reviewed progress of charge/data sheets and discussed with Dean Millslagle, changing priorities for the coming week.. Worked on the Organization and Management Structure of the MHI Fund.

September 26: Reviewed changes in charge/data sheets and pilot test of new version of sheet to be tried out in one FGP in the City Polyclinic. Reviewed material on the MHIF organizational structure and the autonomy programs.

September 27: Reviewed the changes to the charge/data sheets. Met with the FGP professional association to review the purpose, methodology, and process of data collection sheets and the implementation of the FGP Accounting and Financial System. Reviewed materials on computerization of provider accounting and financial systems.

September 28: Reviewed and revised charge/data sheets, and met with office staff to review implementation and training procedures. Began trip report sections on Autonomy and Computerization of provider accounting systems. Reviewed OHD organization job descriptions and organization structure. Wrote paper on Autonomy.

September 29: Traveled to FGP's in Karakol to review, train, and implement the charge/data sheets, as well as to finalize the forms. Reviewed data on OHD organization and management. Wrote paper on Computerized Provider Accounting Systems.

September 30: Worked on Trip Report sections and sections on Autonomy and Computerization of Provider accounting and financial systems, Revolving Drug Fund and MHIF Fundholding development..

October 2: Met with Sheila O'Dougherty and Dean Millslagle on the MHIF Organizational Structure and the FGP's financial systems development. Revisited FGP's to review trial data collection system, and made adjustments to forms and data flow/tabulation.

October 3: Met with FGP's to review data collection once again. Discussed various related issues with Sheila and Dean. Prepared for presentation to AID and Abt representatives coming on Tuesday.

October 4: Reviewed and tabulated data from FGP's, worked on BHI Fundholding Structure and Organization. Met with Tina Cleland (USAID/DC) and Richard Killian (ZRP/Bethesda) to review FGP plans and activities.

October 5:. Worked on Trip Report and various related issues. Reviewed and prepared materials on the Revolving Drug Fund.

October 6: Traveled to Almaty to meet with Charles Krakoff and to begin Revolving Drug Fund Financial Feasibility Study Discussion and Planning for trip to Bishkek, Kyrgyzstan.

October 7: Work in Almaty of the Revolving Drug Fund financial format and data structure.

October 9: Traveled to Bishkek with Charles Krakoff and Michael Borowitz and met with key Government Officials associated with procurement of pharmaceuticals.

October 10: Work in Bishkek on the Revolving Drug Fund.

October 11: Work in Bishkek on the Revolving Drug Fund Feasibility .

October 12: Work in Bishkek on the Revolving Drug Fund Study.

October 13: Travel to Almaty, met with Almaty Office personnel on various issues.

October 14: Traveled from Almaty to Philadelphia via Frankfurt

Annexes

ANNEX A: **References and Bibliography**

ANNEX B: **Persons Contacted**

ANNEX C: **List of Acronyms**

ANNEX D: **Scope of Work**

ANNEX E:

ANNEX A

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ANNEX B

Persons Contacted

Almaty:

Zdrav*Reform* Program :

Michael Borowitz, MD, Regional Director

Rebecca Copeland, Deputy Director

Sheila O'Dougherty, MIS Specialist

Charles Krakoff, Privatization Specialist

Karakol:

Visiting Consultants, USAID, and Abt Representatives:

Grace M. Carter, Resource Management Department, RAND Corporation

Richard Killian, ZRP, Deputy Project Manager for Operations

Tina Cleland, USAID Contract Specialist

Heinecke Werner, Consultant, AGEG, GTZ

Zdrav*Reform* Site Office Staff:

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Naripa Mukanova, Office Manager

Kylych Abdyrahmanov, Administrative Staff

Tokon Ismailova, Physician Statistician

Bakyt Akmatov, Research Assistant

Republic of Kyrgyzstan, Ministry of Health

Ainagul Shaykmetova, Head Basic Health Insurance

Oblast Department of Health:

Salieva, Damira, Oblast Health Department Director

Tolon Kyrgyzhayev, Former Director OHD

Berdikozhoev, Okey, City Polyclinic Head Physician

Buguchiev, Zhaken, Maternity House Head Physician

Moldokanov, Usengary, Pediatrics Head Physician

Baiserkeev, Kubanychbek K., Institute of Management Rector

Maanaev, Toktobai, Chief Physician Ak-Su Rayon Hospital

Ryspaei, Kozhobi, Deputy Head Physician of Oblast Hospital

Sydykov, Mairambek, Deputy Oblast Administrator

Osmonov, Talant, BHI Economist

Eliev, Ilitchbek, Head Physician STD Hospital

Zamir Keneshbekovich, Deputy Head Physician Oncology Hospital

Zholochiev, Bekturgan, Head Physician Psychiatric Hospital

Zamibecova, Anipa, Internist APTK #1

Rahmatova, Gulimra Iskenderovra, Deputy Head Physician Maternity House

Ermekov, Hasipa Epmekovram Deputy Head Physician Pediatrics

Abdraeva, Shaken, Head Physician City Hospital and Polyclinic

Ryspaev, Kozhoby, Deputy Head Physician Oblast Hospital

Abdynalieva, Rose, Pediatrician APTK #3

Imanbekekov, Tilek, Head of Oblast Budgetary Department

Maripa Usupova, Chief Accountant of the Dzhety-Oguz Central Rayon Hospital

Issyk-Kul FGP's Professional Association Meeting (9-27-95) Training

1. Kadyrculova, Zeinap, Dzhety-Ogus FGP 1
2. Ryskulova, Gulbubu, Dzhety-Ogus FGP 2
3. Musabekova, Gulmyikan, Dzhety-Ogus FGP 3
4. Ibraimova, Cholpon, Dzhety-Ogus FGP 4
5. Ashirakhmanova, Gulmira, Karakol FGP 1
6. Asangarieva, Munara, Karakol FGP 2
7. Tolubaeva, Ramilya, Karakol FGP 2
8. Abdynalieva, Rosa, Karakol FGP 3
9. Dean Millslagle, Karakol office
10. George Purvis, Consultant
11. Mukanova, Nuripa, Karakol office
12. Abdrakhmanov, Kylych, Karakol office
13. Asankhodzhaeva, Svetlana , Karakol office
14. Ismailova, Tokon, Karakol office
15. Akmatov, Bakyt, Karakol office
16. Ibragimov, Alisher, Karakol office

ANNEX C

List of Acronyms

ALOS	Average Length of Stay
APTK	Russian acronym for a primary care group practice, consisting of (A) an obstetrician-gynecologist, (P) a pediatrician, (T) a therapist or internist, and in some areas (particularly rural sites) a mid-level practitioner or physician extender (known as a Feldsher, and (K) for complex (APTK)
BHI	Mandatory Health Insurance Fund, also MHI, also Kassa
BHS	British Health Service
FGP	Family Group Practice (new name for APTK or PCGP)
GP	Group Practice or General Practitioner
IDS	Intensive Demonstration Site
IS	Information Systems
KASSA	Cash-holding agency, Mandatory Health Insurance Fund, MHI, BHI
MHIF	Mandatory Health Insurance Fund
MIS	Management Information Systems of Medical Information System
MOF	Ministry of Finance
MOH	Ministry of Health
OHD	Oblast Health Department
NGO	Non Governmental Organization
PCPG	Primary Care Group Practice
PGP	Primary Group Practice
PHC	Primary Health Care

RDF	Revolving Drug Fund
STD	Sexually Transmitted Disease
TB	Tuberculosis
USAID	United States Agency for International Development

ANNEX D

Scope of Work

Name: George P. Purvis III

Dates of Visit: September 17 - October 14, 1995 (4 Weeks)

Collaborating Zdrav*Reform* Team Members:

Sheila O'Dougherty and Dean Millslagle

Work Sites: Karakol, Kyrgyzstan

Local Counterparts:

Head Physicians of the FGP's and DOH representatives

Tasks:

1. To prepare and conduct a two-day workshop for the BHI Board of Directors and two one day workshops for area hospitals

2. To implement Stage I of Data Collection/Information and Finance System for FGP'sin existing physician groups, including training of physicians and staff.

3. To continue the design and development of Stage II of the financial system for FGP's.

4. To assess the planning and implementation progress of the Fundholding System.

Outputs:

1. Workshop materials package, report on workshop results, issues and recommendations for follow up actions for the Board of Directors development.

2. Finalize design and pilot test implementation of Stage I of information/finance system for group practices.

3. Outline specifications for Stage II of Financial Systems.

4. Recommendations on next steps in the implementation of the BHI Fundholding System.

EXHIBITS

EXHIBIT 1: **Abstract**

EXHIBIT 2: **Job Descriptions of OHD Staff**

EXHIBIT 3: **OHD Organizational Chart**

EXHIBIT 4: **Charge/Data Sheets**

EXHIBIT 1

Abstract: Development of Family Group Practice Accounting and Financial Management Systems

Prepared by: George P. Purvis and Bakyt Akmatov

The implementation of an Intensive Health Reform Demonstration Project in the Issyk-Kul Oblast, Kyrgyzstan, had identified as an early priority the development of improved primary medical care services to the population. The strategy for effective implementation was the establishment of a large number of independent family group practices, originally called APTK's, from the former Soviet definition of one Ob/Gyn, one Pediatrician, and one Internist, working together in a family practice environment. It is envisioned that the number of group practices could eventually reach a total of 100 groups, covering a population, both urban and rural, of approximately 440,000 people. The strategy of developing more primary medical care services was also supported by a Mandatory Health Insurance Fund (MHIF), which would pay these group practices on a capitation method of reimbursement. In order to support the development of these groups, now called Family Group Practices (FGP's), a number of interventions were required including a professional association, education, training, equipment, supplies, drug procurement, an office location, renovations, a formal legal status, selection of the physicians, formation of the groups, and the support of an information, accounting, and financial system. This abstract outlines the specifications and requirements of the accounting and financial management system for these FGP's.

The movement of a number of primary care physicians out of the polyclinic structure into a new independent family practice environment requires a number of changes to methods of operations and management of personnel, revenues and expenses. The existing method is the Department of Health (DOH) system of budget chapters and a cash basis, fund accounting approach to the management of revenues and expenses. These family group practitioners are clinical physicians without business experience and are leaving the financial support of the DOH. In order to make a smooth transition from the existing system to a new system, it was important that many attributes of the old system were retained, and yet a new method be developed to assist the independence of these groups from the DOH.

Due to the lack of computerization in the initial stages of the project, one requirement was the specification that the initial information, accounting, and financial management system be a "manual" approach to the collection and reporting of information. A preliminary investigation identified a system known as the "pegboard" system, which is presently utilized in thousands of physician and dental offices in a number of countries and available in a number of languages. The pegboard designation refers to the position board, which has pegs in it to align the various forms which the system utilizes. The pegboard approach is a manual business system covering the full range of accounting

functions: Revenue, Cash Collections, Payroll, Accounts Receivable/Payables, Journals, Ledgers, etc. The system is also known as a "one write" system (as each transaction needs to be written only one time), has built in audit controls, and is essentially fraud proof (if operated as developed). The vendors supplying these pegboard systems provide a full range of encounter forms, superbills (for insurance), patient billing statements, envelopes, mailers, related equipment (the pegboard, trays for patient account cards) and supplies for appointments, stationary, labels, telephone message pads, patient history and progress notes, prescription pads, file folders, etc. The system also lends itself to an easy transition to computerization in a later phase.

The development of these FGP's and the implementation of information, accounting, and financial systems including collection of fees, an independent bank account for the group practice, and a number of new clerical and management tasks, including equipment, supplies, renovations, and personnel administration produced the need for a supervisor, or group practice manager. The establishment of this position at the creation of the FGP's was felt to be critical to their long term success. The creation of this type of position was identified and justified, and candidates selected from a local business college. In the initial stages it is envisioned that one group practice manager could oversee two FGP's. The early stages of implementation of the pegboard business system began with the information phase (data for the MHIF), followed by the revenue side (user fees and payment from the MHIF), and eventually working into the expense side (personnel salaries, supplies, rent, etc.) as the group practices become truly independent of the Department of Health.

EXHIBIT 2

Job Descriptions of OHD Staff

Position: Head of Oblast Heath Department Administration
Name: Salieva, Damira
Responsibilities:

1. General supervision
2. Solution all planning- financial issues
3. Organize and check the emergency anti-epidemiological committee work, medical civil defensive service work, transport work and logistics
4. Provide assistance and coordination for Red Cross and Mercy Corps activities
5. Solution of labor issues and accident prevention questions.
6. Identify candidates for selection, supervision of their work

Position: Deputy Head of OHD Administration
Name: Ryspaev, Kozhobil
Responsibilities:

1. Supervision and coordination of mid level medical personnel work, nursing school, medical - juridical expertise work, Medical information center work
2. Monitor and management of the development of MHI and other health care reforms
3. Analyze the letters, applications, and complaints from staff
4. Introduce new equipment and health service innovations to Public Health
5. Deputy Head is acting head if Head is on vocation or on business- related travel

Position: **C**hief Internist
Name: Temirbaeva, Tamara
Responsibilities:

1. Supervision of dispensary, polyclinic, laboratory, infectious disease, cardiology, physiotherapy, blood, allergies, gastro-enterologic, pulmonologic, nephrologic, anti- tuberculous, endocrinologic services, psychological and neurologic services
2. Provide medication to the population
3. Provide medical assistance and servicing for invalids and WWII participants, industrial enterprise workers and agriculture workers
4. Organization of adult's and children's checking up, medical - resort treatment and diet in medical facilities
5. Provide medical servicing for teenagers, draftees and supervision of selective service commission work

Position: **C**hief Surgeon
Name: Ibraev, Shergasy
Responsibilities:

1. Supervision of surgical, intensive care, blood transfusion, traumatologic, oncologic, radiologic, dental, otolaryngological, ophthalmological and urological services
2. Monitor of judicial expertise, first aid and urgent aid, pathology/anatomical services

Position: **C**hief Obstetrician/Gynecologist
Name:
Responsibilities:

1. Supervision of obstetrician/ gynecological, STD, genetic, children gynecological services
2. Organization of medical assistants and obstetricians, outpatient clinics work
3. Solutions to family planning issues and home visits

Position: **C**hief Pediatrician
Name: Artykbaeva, Zhyldyz
Responsibilities:

1. Supervision of pediatric services
2. Analyze infant mortality and number of cases, check the fulfillment of preventive measures
3. Monitor of the development of "Healthy Nation" program
4. Supervision of the immunoprophylaxis center work
5. Provide medical servicing for schools and nursery schools
6. Check the fulfillment of own and local authorities orders

Position: Civil Engineer
Name: Saburov, Shodi
Responsibilities:

1. Supervision of major construction, repair in medical facilities, transport, use/operating and repair of medical equipment
2. Solution to labor issues and accident prevention, fire- prevention questions
3. Provide medical facilities preparation for winter time
4. Save operating on transport farm tools and equipment

Personnel department

Position: Inspector
Name: Akmatova, Ziyagul
Responsibilities:

1. Keeping inventory of personnel document on Unified government system of keeping track of activities.

Position: **E**conomist
Name: Akmatova, Gulnura
Responsibilities:

1. Gather and analyze economic data of oblast medical facilities
2. Training of oblast medical facilities supervisors and economists to manage MHI by economic methods
3. Provide supplies for medical facilities

Position: Head of Medical Information Center
Name:
Responsibilities:

1. Word processing and data entry (daily)
2. Select monthly information of oblast medical facilities statistical data

Position: Oblast Chief Nurse
Name: Khaluchenko, A.
Responsibilities:

1. Supervision of mid- level medical personnel work, nursing school
2. Keeping inventory and utilization of medication by order of oblast medical facilities

Position: Chief Accountant
Name:
Responsibilities:

1. Perform all accounting functions
2. Monitor the centralized accounting department work
3. Training of oblast medical facilities accountants
4. Analyze the oblast medical facilities financial activities and logistics on accounting data

EXHIBIT 3

OHD Organizational Chart

EXHIBIT 4

Charge/Data Sheets